

NOTICE OF PRIVACY ACKNOWLEDGMENT

I understand that Willamette Surgical Specialists LLP, Willamette Dermatology PC, Willamette General & Colon-Rectal Surgery PC, & Willamette Surgical Clinic PC (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as the **Privacy Notice** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Privacy Notice may be revised from time to time, and that I am entitled to receive a copy of any revised Privacy Notice. I also understand that a copy of the most current version of this Practice's Privacy Notice in effect will be available in the waiting/reception area or I can obtain a copy from the receptionist.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Privacy Notice, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Privacy Notice.

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority: _____	